Income Protection Insurance
Membership Application

Omega Financial Management

dg mutual

IMPORTANT NOTES – PLEASE READ BEFORE COMPLETING THIS FORM
When you complete this application form you should be aware that you must disclose all material facts. A material fact is any information that is likely to affect our decision to accept your application or the amount of subscription you pay. You are obliged to disclose this type of information to us, even if the application form has not asked specific questions about it. So, if you are unsure whether a fact is material or not, you must include it on your application form. Failure to disclose all material facts could result in your application being rejected, or you could find that your policy is invalid when you make a claim and no benefit will be payable. We will rely on what you tell us and you must not assume that we will clarify or confirm any information that you have provided with your medical attendants. Any rates, subscriptions or benefits indicated by the Society in any literature are based on an application being accepted on normal terms. The Society reserves the right to decline membership or offer membership on different terms based on the information shown on the application form or received from other sources.

SECTION 1

(i) PERSONAL DETAILS

Gender: (please tick) M☐ F☐

Title: (please tick) Dr☐ Mr☐ Mrs☐ Miss☐ Ms☐

Surname: .....

Forenames: .....

Private Address: .....

.....

Telephone: .....

E-mail: .....

Business Address: .....

.....

Telephone: .....

E-mail: .....

Date of birth: .....

Place of Birth: .....
(Town) (Country)

If your place of birth is not in the Republic of Ireland how long have you resided here?

.....

Have you ever resided or have any prospect or intention of residing outside the Republic of Ireland?
(please tick) Yes☐ No☐

Do you intend to engage in flying other than as a fare paying passenger?
(please tick) Yes☐ No☐

Please list any competitive sports, hobbies or activities likely to cause injury in which you currently or intend to participate.

.....

.....

Source of introduction.

.....

(ii) EMPLOYMENT DETAILS

Profession or Occupation (please be precise)

.....

For how long have you been so employed? (years)

.....

Are you self-employed?
(please tick) Yes☐ No☐

If yes, for how long? .....

What is your average weekly gross income?
(Net pre-tax earnings if self-employed) € .....

In the event of incapacity for how long would you receive income or benefit from any source and at what rate €.....per week for.....weeks.
If more than one source, give full details separately.

If employed are you on a fixed term contract?
(please tick) Yes☐ No☐

If so, please provide the date the contracts ends.

.....

(iii) OTHER INSURANCES

Have you ever been refused or offered insurance on terms other than standard, for a life, accident or sickness policy?
(please tick) Yes☐ No☐

If yes, please give details here or separately.

.....

.....

Do you have, or have you applied for, sickness or accident insurance here or elsewhere?
(please tick) Yes☐ No☐

If yes, please give details here or separately.

Name of Company or Society: .....

Weekly Benefit: .....

Deferred Period: .....

If you have this type of cover elsewhere will it continue?
(please tick) Yes☐ No☐

SECTION 2

HEALTH DETAILS

Please answer every question. If you answer YES to any question please use the space provided on page 3 to give full details, including dates, time off work and current prognosis.

a. Name and address of your Doctor

.....

.....

b. How long have you been registered with your doctor?

.....

(if less than 6 months please provide your previous Doctor's details below)

.....

.....

.....

c. Please state your weight .....

d. Has there been any increase or loss in your weight in the last year? Yes☐ No☐

e. Please state your height .....

f. Have you ever smoked? Yes☐ No☐

If yes, how many per day? .....

g. What is your average weekly consumption of alcohol in units?

Units .....

1 pint beer = 2 units |1 glass wine/measure of spirits = 1 Unit

h. Have you been advised to reduce your alcohol intake? Yes☐ No☐

i. Are you currently undergoing any treatment or awaiting any referral, tests, results or surgery? Yes☐ No☐

j. Are you at present suffering from any disease, disorder or disability? Yes☐ No☐

k. Have you ever taken or are you currently taking any drug not prescribed by your Doctor? Yes☐ No☐

l. Have you consulted any other health professional such as a Chiropractor or Osteopath? Yes☐ No☐

m. Have you ever tested positive for HIV/Aids, Hepatitis B or C or any sexually transmitted disease? Yes☐ No☐

Have you ever had: (please tick)

1. Anxiety, stress, depression, fatigue, breakdown or counselling? Yes☐ No☐

2. Back, neck or shoulder pain, disc problems? Yes☐ No☐

3. Arthritis, joint, bone, ligament or muscle problems? Yes☐ No☐

4. Chest, lung, breathing problems including asthma and bronchitis? Yes☐ No☐

5. Heart disease, including heart attack, angina, chest pains or heart defects? Yes☐ No☐

6. Digestive system, stomach, bowel or liver problems? Yes☐ No☐

7. Any disorder of the genito-urinary system, kidneys, bladder or prostate? Yes☐ No☐

8. Blood pressure problems or blood disorders? Yes☐ No☐

9. Skin disorders or allergies? Yes☐ No☐

10. Eye or ear problems? (You can ignore sight problems corrected by glasses or lenses) Yes☐ No☐

11. Diabetes or impaired glucose intolerance? Yes☐ No☐

12. Debility, post viral/chronic fatigue syndrome or ME? Yes☐ No☐

13. Migraine attacks, fits, faints, blackouts or paralysis or any disorder of the central nervous system? Yes☐ No☐

14. Hernia, haemorrhoids or varicose veins? Yes☐ No☐

15. Tumours, cancers or growths? (including leukaemia or Hodgkin's disease) Yes☐ No☐

16. Any Gynaecological, menstrual, uterine or breast disease/disorder? Yes☐ No☐

17. Any other illness, disability, mental or physical impairment or previous consultation that might be relevant to this application? Yes☐ No☐

SECTION 2

HEALTH DETAILS (Continued)

If you have answered YES to any of the questions in Section 2 please give full details, continuing on a separate sheet if necessary. Please note that failure to disclose relevant information could mean that we will reject your claim and your policy will be cancelled.

Question Ref	Details	Dates

Please give details below of the last time you sought medical advice if it was within the last three years (including the name and address of the medical practitioner if different to that given at 2a). Show dates, nature of incapacity and indicate any time away from work.

.....

.....

Please provide details if any of your immediate family have been diagnosed with or died from any of the following diseases before the age of 65. Heart disease, stroke, diabetes, kidney disease, cancer, multiple sclerosis, raised blood pressure. Alzheimer's disease, motor neurone disease, Parkinson's disease and any hereditary disorder including Huntington's disease.

	Conditions (if diagnosed with cancer please advise site)	Age at Diagnosis	Age at Death (if applicable)
Father			
Mother			
Brother(s)			
Sister(s)			

SECTION 3

BENEFITS REQUIRED

Please indicate the amount and type of cover you require. Under the limitation of Benefits Clause the maximum you may apply for is 66% of net pre-tax earnings, less any other continuing income or insurances. Each bond provides €20 per week benefit and cover is available from €60 to €1500 per week.

1. Weekly Benefit Required €

All applications for benefit above €800 must be supported by proof of earnings. For the employed – Original printed payslips or P60. For the self-employed - Original most recent accounts or Revenue Notice of Assessment.

2. Benefit from (please tick) **Day One**☐ **4 Wks**☐ **8 Wks**☐ **13 Wks**☐ **26 Wks**☐ **52 Wks**☐

3. Constant (please tick) ☐ **Reducing** (N.B. Reducing benefit is available for Day One cover only) ☐

I do/do not wish to receive a copy of this application form (please delete)

SECTION 4

DATA PROTECTION

- The information you provide will be held by the society in accordance with the UK Data Protection Act 1998 and it will be used in the administration of the policy.
- A copy of the application form and any supporting documents, including financial and medical reports may be given to a reassurance company where the risk is shared with such a company.
- We reserve the right to discuss any relevant aspects of your medical treatment or examination with the providers of those services.
- Medical information provided will be used for underwriting and claims purposes only and your consent is required for us to use, hold and retain it. It will not be supplied to any other third party without your consent, unless it is lawful to do so.
- Information may be released to your financial advisor to enable them to give you advice. This will not include medical information. If your financial advisor no longer represents you it is your responsibility to notify us.
- The information you provide to Omega Financial Management Limited will be held by them in accordance with the Irish Data Protection Acts 1998 and 2003.

MEDICAL REPORTS ACT 1988

Summary

Before we can apply for a medical report from your doctor we need your consent. Before signing in the space below you should know you have certain rights under the UK Access to Medical Reports Act 1988. The main points are as follows:

1. You can withhold your consent.
2. You can see the report before it is sent to us provided that you apply to the doctor within 21 days or during the six months after that. The doctor may charge you a fee for providing the report to you.
3. You can ask the doctor if he will amend any part of the report which you consider to be incorrect or misleading. If the doctor is not in agreement, you may amend your comments.
4. The doctor can withhold from you the report, or part of it, if he thinks you would be harmed by seeing it.

Full details of your rights under the Act are available on request.

Declaration and Consent to Obtain a Medical report

I hereby declare that I am the person referred to in this application form, that I have read over my answers to all the questions and to the best of my knowledge and belief that the information provided is true and complete. I am aware that subscriptions increase with age and have noted the information relating to the Limitation of Benefits.

I have been informed of my statutory rights under the UK Access to Medical Reports Act 1988, as explained above, and in connection with my application, hereby consent to The Dentists' and General Mutual Benefit Society Limited being provided with medical information, including copies of my medical reports, from any doctor that has attended me regarding my physical and mental health and I agree that a copy of this consent shall have the validity of the original. I undertake to inform the Society if I obtain additional similar insurance in the future or if any medical fact arises or changes before membership is in force.

☐ I wish to see the report before it is sent to the Society

Name (block capitals)	
Signature	Date:

SECTION 5

(a) DECLARATIONS

- I submit this application, along with any subsequent information provided in relation to this application, verbally or otherwise, by me or an agent acting on my behalf, with a view to entering into a contract for the benefits set out herein.
- I understand that the policy will commence on the commencement date indicated on the policy or on such other date as notified by DG Mutual, the underwriters of the policy.
- I understand that terms and conditions, as provided to me will apply and that this policy is governed by, and will be construed in accordance with, the laws of the United Kingdom.
- I have read over the replies to all questions in this application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history, may delay or prevent the issue of my policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it.
- I consent to DG Mutual, verbally or otherwise, seeking and receiving additional information from me or my agents where this information has not been provided on the application or where future information, including medical information, is required in order to process the application and such information will be deemed to be incorporated into this application.
- I undertake to inform DG Mutual of any change in my country of residence during the life of the policy.
- I understand that in the interest of customer service and to ensure the accuracy of records, telephone conversations between DG Mutual and me may not be recorded.
- I understand that DG Mutual will not refund premiums retrospectively, prior to me advising DG Mutual of the cancellation or alteration of this policy. It is my responsibility to notify DG Mutual of any change in my circumstances.

(b) LIFE ASSURANCE (PROVISION OF INFORMATION) REGULATIONS, 2001

DECLARATION UNDER REGULATION 6(3) OF THE LIFE ASSURANCE (PROVISION OF INFORMATION) REGULATIONS, 2001

WARNING If you propose to take out this policy in complete or partial replacement of an existing policy, please take special care to satisfy yourself that this policy meets your needs. In particular please make sure that you are aware of the financial consequences of replacing your existing policy. If you are in doubt about this, please contact your insurer or insurance intermediary.

Declaration of insurer or Intermediary:

I hereby declare that in accordance with regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001, _____ (the client) has been provided with the information specified in Schedule 1 to those regulations, that I have advised the client as to the financial consequences of replacing an existing policy with this policy by cancellation or reduction, and of possible financial loss as a result of such replacement.

Signature of Financial Adviser: …… Date:……

SECTION 5 (Continued)

Declaration of client:

I confirm that I have received in writing the information specified in the above declaration.

DG Mutual or its authorised agents may hold, use, disclose and process any information provided by me, which shall include the information held within this application and any subsequent information, provided verbally or otherwise, during the course of our relationship, in order to:

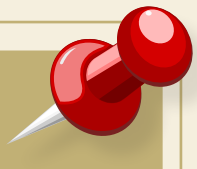
1. Process, manage and administer my policy
2. Communicate with me by post, telephone or email
3. Comply with legal and regulatory requirements
4. Disclose data to any policyholder, life assured, beneficiary, trustee, assignee, successors or any agent acting on your behalf or to other discloses as notified to the Data Protection Commissioner's Office and maintained on the Public Register available from that office.

I am aware that I have the right of access to my personal data and the right to rectify my data if it is inaccurate or has been processed unfairly. I consent to DG Mutual collecting and processing sensitive data relating to my mental and physical health. I consent to DG Mutual seeking medical information from any doctor or medical professional who has at any time attended me concerning anything which affects my physical or mental health. I agree that this authority shall remain in force after my death as well as prior thereto. I further understand that in the event of me being medically examined the answers given by me to the medical examiner acting on behalf of DG Mutual shall be deemed to be incorporated into this application. Please note that failure to consent to the above will prevent DG Mutual from processing your application Further. Furthermore, failure to answer any question contained herein may result in DG Mutual refusing to accept your application or denying a claim. Your personal data may also be used to send you details about other similar services available from DG Mutual. If you do not wish to avail of this service, please tick this box ☐

WARNING The current premium will increase on the ____/____/_____ and every five years thereafter

Signature of Policy Owner: ..... Date:.....

Have you enclosed?



☐ Completed Direct Debit Mandate

☐ Proof of age i.e. Passport, Driving Licence or Birth Certificate

☐ Evidence of earning (application above €800 p.w. benefit)

INSTRUCTION TO YOUR BANK TO PAY DIRECT DEBITS

To Policyholders

Direct Debiting is a simple, inexpensive and convenient way of paying your Premium. All you need to do is sign and return the Mandate which authorises your Bank to debit your current account when the Premiums are payable. The processing of the Mandate may result in some delays in collecting the first Premium(s). Such delay does not affect your rights under the policy and the Company's liability commences when we issue our notification or acceptance of risk.

The Mandate has been designed so that you do not have to enter the amount of your Premium. No collection of Premium will be made before it is due and the amount collected will be stated in your policy. The company will make immediate reimbursement in the unlikely event of an error resulting in overpayment. We have also given your bank an indemnity to this effect. You may cancel your Direct Debit Mandate at any time by notifying your Bank and you should also notify us of the cancellation.

After completion please return the mandate to DG Mutual.

The Dentists & General Mutual Benefit Society Ltd trading as DG Mutual is authorised by the Prudential Regulation Authority in the United Kingdom and is regulated by the Financial Conduct Authority and the Prudential Regulation Authority in the United Kingdom.

Please detach and retain the upper section of this document

DG Mutual SEPA Direct Debit Mandate

Unique Mandate Reference (UMR) - to be completed by DG Mutual

By signing this mandate form, you authorise (A) DG Mutual to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from DG Mutual.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.
Please return this mandate to DG Mutual St James Court, 20 Calthorpe Road, Birmingham, B15 1RP

Please complete all the fields marked *

Debtor Correspondence Details

Name* .....

Address* .....

Debtor Name(s)* .....
(Name on Account)

Debtor sort number .....

Debtor account number .....

Debtor IBAN* .....

Debtor account identifier code BIC* .....

Please ***sign*** here* .....

Date of signature* .....

Creditor's name	DG Mutual
Creditor identifier	E66ZZZ307401
Type of payment	Recurrent Payment

By signing this mandate form, you agree to an advance payment notification period of three days before the first collection is debited from your account.

Policy Number Date